Virginia Department of Medical Assistance Services

Encounter Data Submission Manual for Managed Care Organizations

Version 1.0

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Version Change Summary

Version No.	Description	Date
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I. INTRODUCTION

A. Background

Since the Commonwealth of Virginia introduced the Medallion II Medicaid managed care program in 1996, it has grown steadily and currently comprises the largest segment of Medicaid enrollees. Medallion II is a full-risk Medicaid managed care program, and is mandatory for most Medicaid recipients.

The Commonwealth's Department of Medical Assistance Services (DMAS) is the agency that oversees the Medicaid managed care programs, and its mission statement is to "provide a system of high quality and cost effective health care services to qualifying Virginians and their families." [1] More specifically, the Managed Care Unit of the Division of Health Care Service is responsible for implementing programs, providing oversight, and monitoring the managed care organizations (MCOs) to ensure compliance with Federal and State regulations for medical assistance programs.

In order to comply with its responsibilities, DMAS must have access to transactional records of health care and related services including transportation, dental, and prescription drugs that are provided to DMAS' managed care enrollees. Therefore, all MCOs must provide records of these services that are rendered to Medicaid managed care enrollees, regardless of the payment mechanism employed by the MCO for its providers. In other words, records for services rendered under capitation arrangements and services paid on a fee-for-service basis must be submitted to DMAS. Throughout this document, the term "encounter" will be used to reference these transactional records of health care and related services.

Effective June 16, 2003, DMAS required all MCOs to submit encounters using the HIPAA-mandated electronic formats and specific protocols specified in Section IV of this guide. In order to improve the consistency and accuracy of the encounters reported by the MCOs, DMAS is publishing this Encounter Data Submission Manual. This manual contains information to assist existing and prospective MCOs in developing processes and procedures for encounter data submission.

B. Required Encounter Data

All encounters processed by the MCO or any MCO subcontracted vendor should be submitted to DMAS in the prescribed format, including records that were denied for most reasons.

The exceptions, which should NOT be submitted to DMAS, are:

- Encounters that are rejected by the MCO
- Encounters that are duplicates of records previously submitted by the provider

[1] Overview of the Department of Medical Assistance Services, Revised August 2005

- Encounters that contain an invalid Medicaid recipient identifier
- Encounters for Medicaid recipients who are not enrolled with your MCO

If the encounter being submitted is one that you have denied, the encounter should be submitted to DMAS with the appropriate denial reason code from the Adjustment Reason Code set (code source 139) appearing in the first CAS segment of the encounter (see Data Clarification documents).

1. Global Billing Arrangements

If the MCO contracts or pays any services under a so-called "global billing arrangement", such as for maternity and delivery services, DMAS expects to see encounters for all services that were rendered under such an arrangement, not just the encounter that triggered the payment. The MCOs are responsible for ensuring that providers submit all appropriate records in connection with services paid under a global billing arrangement.

2. Data from Subcontracted Vendors

If the MCO subcontracts with any agency to process encounters or provide services, such as laboratory services, the MCO is responsible for assuring that data from these vendors contain all the information necessary to create the appropriate 837 encounter record. The MCO is also responsible for verifying the accuracy of these data, particularly with respect to the edits it would apply if the data were received directly from the provider rather than through a subcontracted vendor.

C. Claim and Service Line Adjudication

All transactions submitted in an 837P (Professional) transaction must be adjudicated at the service or line level. Likewise, institutional transactions (837I) for *outpatient* services that contain procedure codes should be adjudicated at the service level. Other institutional transactions may be adjudicated at either the claim or service level.

Revenue Codes on institutional transactions are always provided at the service level; MCOs adjudicating inpatient transactions at the claim level may "roll" like Revenue Codes into a single service line with associated costs; e.g., all ancillary services reported on one line as Revenue Code 0240 (All Inclusive Ancillary – General Classification). MCOs are NOT required to summarize like Revenue Codes; each code may be reported separately if that is how the MCO stores the information.

D. Adjustments and Voids

If the MCO or the MCO's provider adjusts or voids a claim that has been or will be submitted to DMAS, the MCO must submit that void or adjustment to DMAS as well. DMAS has the following requirements with respect to adjustments and/or voids:

1. If you are adjusting or voiding one service line on a claim that has more than one line, you must include all lines on the adjust or void.

2. The order in which the service lines appear on an adjusted or voided claim must be the same as on the original claim. DMAS does not collect the MCO's line number; hence the original order must be preserved.

3. The claim number that appeared on the original claim must be coded in Loop 2300, REF Segment of the 837 (see page 180 of the professional or page 198 of the institutional ASC X12N Implementation Guide, Version 4010A1). If the number in this segment does not match the original claim number, the record will receive a fatal error.

4. If you submit the adjustment or void record in the same file as the original record, the original record must appear first in that file. Please also keep the lines of the original, adjustment and/or void in the same order.

II. HIPAA ADMINISTRATIVE SIMPLIFICATION

A. Background

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require that all covered entities, which include health plans, must use standard transaction sets when exchanging certain information. The initial HIPAA regulations specified a number of transactions or communications that were to be covered by the regulations, and they included health care claims.

HIPAA did not specifically define the exchange of encounter data between a Medicaid plan and a managed care organization as a covered transaction. However, since health care claim transaction sets are national standards for data exchange, DMAS elected to use the HIPAA transaction sets as its standard for encounter data submission.

B. Transaction Sets

1. Version and Model

As of this publication date, DMAS is using a variation of the Provider-to-Payer-to-Payer COB model of the 837 transaction sets, Version 4010, Addendum 1 for facility, professional, and dental services. For prescription drugs, the mandated transaction set is the NCPDP Version 5.1 Telecommunication Standard.

As new versions of the transaction sets are adopted by HIPAA, DMAS will use the newer versions in accordance with HIPAA requirements.

MCOs should use the matrix below to determine which transaction set is appropriate for the type of encounter to be reported (based on billing entity):

Billing Entity	Transaction
Inpatient Urgent Care Facility	837 Institutional
Outpatient Urgent Care Facility	837 Institutional
Inpatient Mental Health Facility	837 Institutional
Outpatient Mental Health Facility	837 Institutional
Federally Qualified Health Center	837 Professional
Long Term Care Facility/Skilled Nursing Facility	837 Institutional
Home Health Provider	Either 837 Institutional or 837 Professional, depending on contract between the MCO and the provider.

Billing Entity	Transaction
Pharmacy Benefit Manager/Retail Pharmacy	NCPDP
Hospital Pharmacy	837 Institutional
Independent Laboratory	837 Professional
Hospital-based Laboratory	837 Institutional
Dental Provider	837 Dental
Non-Emergency Transportation	837 Professional
Emergency Transportation	837 Professional
Hospital-based Clinic	837 Institutional
Free-standing Clinic	837 Professional
Physicians	837 Professional
Other medical professionals	837 Professional

If in doubt about the format to use for a specific type of claim, please contact: Jill Gambosh, Encounter Analyst, at 804-786-7346 or the Electronic Commerce Customer Support Line at 800-924-6741.

2. Implementation Guides

Detailed information on how each of the 837 transaction sets should be used is contained in each Implementation Guide (IG) and its corresponding Addendum. There are separate IGs and Addenda for professional, institutional, and dental services and they can be downloaded for free at www.wpc-edi.com. Note that the professional IG is the basis for non-emergency transportation encounters. The same site also has purchase options for the IGs, which can be quite lengthy and take some time to download and/or print.

The IGs and Addenda provide details about which loops, segments and data elements are required in various health care situations. If MCOs carefully follow the instructions in these IGs and Addenda, the certification and testing processes outlined in Sections IV.C and IV.D should be completed smoothly and expeditiously.

For prescription drug encounters, the NCPDP documentation is available through its Web site – www.ncpdp.org. This site also contains other helpful information for implementing this transaction set.

3. DMAS Documentation

To further assist MCOs in the encounter data submission process, DMAS is providing other information that MCOs should review. These documents include:

- Encounter Data Submission Manual at https://virginia.fhsc.com/providers/Manuals.asp
- Companion Guides at https://virginia.fhsc.com/hipaa/CompanionGuides.asp
- Data Clarifications at http://www.dmas.virginia.gov/mc-encounter.htm

The Companion Guides are not specific to encounter data, but may contain helpful information not found in the Data Clarifications or this Encounter Data Submission Manual.

4. Other Documentation

WEDI, the Workgroup for Electronic Data Interchange, is an organization that was formed specifically to promote and assist in the development of better information exchange and management in health care. WEDI's Strategic National Implementation Process or SNIP was formed to facilitate the implementation of national standards, such as HIPAA, within the health care industry. The SNIP Web site provides a wealth of information from white papers on numerous topics to workgroups and LISTSERVS. You can access the WEDI site at www.wedi.org and follow the links to SNIP.

Other Web sites MCOs may find helpful in understanding the HIPAA regulations and in preparing HIPAA-compliant transaction sets include:

> www.cms.gov Follow the HIPAA links for HIPAA Administrative Simplification to access information on the regulations, education, and code sets
>
> www.x12n.org X12 is the accredited standard committee for electronic data interchange across the US and "n" is the workgroup assigned to EDI transactions in insurance, including health care. Work and task groups under ASC X12N developed the transactions sets and implementation guides that have been adopted under HIPAA.
>
> http://www.hipaa-dsmo.org/Main.asp This site contains information on designated standard maintenance organizations, which are groups formed under HIPAA for the maintenance of HIPAA standards and changes required to them.

Most of the above sites also contain links to other sites that may provide additional assistance with implementation of outbound HIPAA transaction sets.

C. Code Sets

Another requirement of HIPAA was the adoption of national code sets for use in all transaction sets. These code sets include most of the information currently codified in the UB92 and CMS 1500 paper claims and their electronic counterparts. Information about the required code sets can be found at the wpc-edi and NCPDP Web sites. One impact of this provision of HIPAA was with respect to so-called "local" procedure codes. These codes are no longer considered valid; only valid procedure codes adopted for national use should be coded in transaction sets.

Also impacted by the national codes requirement are dental codes. Prior to October 2003 the American Dental Association's (ADA) Current Dental Terminology or CDT codes all started with a lead zero. Because of the confusion this can cause with CPT anesthesia

codes, which also start with zero, the ADA agreed to maintain its CDT code set with a lead “D”, as was the case with the HCPCS dental codes. All dental codes should begin with a “D”.

III. ENCOUNTER DATA CLARIFICATIONS

A. Background

The HIPAA implementation guides and Addenda are the official standard for electronic submission of health care claims data. However, there are many areas in these IGs that are situational, open to interpretation, or that require further clarification by the receiving entity. In order to clarify its needs for encounter data from the 837 transaction sets, DMAS has developed Data Clarifications for the institutional, professional, and dental transaction sets. The intent of the information in the Data Clarifications is not to override or replace anything in the HIPAA IGs. The sole purpose of the Data Clarifications is to provide the MCO or contracted vendor with a more thorough understanding of DMAS's data needs and of the data elements it will be using from the transaction sets.

DMAS's fiscal agent , First Health Services Corp. (FHSC), has published Companion Guides for each of the transactions it accepts from providers and MCOs. These Guides are not specific to managed care encounter data and are also used by payers or providers submitting third party liability claims. The Data Clarifications are specific to encounter data submitted by the MCOs and vendors with which DMAS has contracted. Nothing in the Data Clarifications should conflict with information in the Companion Guides; if you identify an area that seems to conflict, please notify DMAS by contacting Jill Gambosh, Encounter Analyst, at 804-786-7346.

B. Using the Data Clarifications

The Data Clarifications are to be used in conjunction with the HIPAA IGs and Addenda, not in place of them. The clarifications provide supplementary information and, when used with the IGs, will produce a transaction set that will meet DMAS's data needs. The Data Clarifications contain all of the data elements that DMAS currently uses from each transaction set; they do not include all required and/or situational data elements that are necessary to produce HIPAA-compliant transaction sets.

C. Accessing Data Clarifications

The following data clarifications have been prepared for use by the MCOs and other vendors submitting claims to DMAS:

837 Institutional
837 Professional (includes MCO non-emergency transportation transactions)
837 Dental (for use by Doral Dental only)
837 Non-Emergency Transportation (for use by LogistiCare only)

Data Clarifications are included as Appendices to this Encounter Data Submission Manual, but we recommend that you access these documents on line in order to assure use of the most current version. The documents may be found at www.dmas.virginia.gov/mc-encounter.htm

IV. ELECTRONIC DATA SUBMISSION

A. Service Center Registration

All MCOs must submit encounters to DMAS electronically using the appropriate HIPAA-mandated transaction sets noted in Section I.B above. MCOs must be registered with the EDI Coordinator at DMAS's fiscal intermediary, FHSC, as a Service Center.

Registration as a Service Center involves the completion of three forms that are faxed to the EDI coordinator at FHSC to initiate the process: (1) Submission of Electronic Transactions Agreement for Service Centers, (2) Service Center Operational Information, and (3) Provider Service Center Authorization. The required forms and instructions for completing them are available in the Service Center Manual that can be found at https://virginia.fhsc.com/providers/Manuals.asp.

Once FHSC has received these forms from the MCO and verified their accuracy, it will assign a four-digit Service Center ID to the MCO within 24 hours of receipt of a completed form. If the service center ID is not received within that time period, please follow up with FHSC at 1-800-924-6741. This number will identify the MCO as a registered service center and is required in numerous data elements in the 837 transactions.

B. Data Transmission Protocol

Virginia Medicaid has implemented a secure method of transferring files electronically that requires the service center to establish an SSL (Secure Socket Layer) connection. In addition, MCOs will need to purchase a form of FTP server/client software for sending and receiving data electronically that will support 128-bit Explicit SSL encryption. Please see the manual referenced in IV.A above for additional information on FTP software requirements. The manual also provides instructions for connecting to the FHSC server, including password requirements and minimum setting requirements.

C. Third-Party Certification

DMAS requires that all entities sending encounter data to FHSC provide proof of transaction testing and certification. At a minimum, certification should confirm that the service center has produced valid transactions through Level II prior to sending any files for testing. Level II testing ensures that the transactions will meet HIPAA syntactical requirements. DMAS will certify its outbound transactions to Level IV, which ensures compliance at the situational level. We encourage MCOs to test through this level as well, although certification through Level II is all that is required. Certification is available from vendors, such as Claredi and Foresight.

D. Test Transmissions

Prior to submitting production files of encounter data, each MCO is required to first test their outbound transactions with FHSC to ensure that the transactions meet DMAS

expectations. DMAS has established some guidelines and limits for transaction testing, as follows:

1. Number of records in test transmission

For the 837 the limits are 5,000 claims or 10% of a normal production month, whichever is less. For NCPDP the limits are 3,000 claims or less.

2. Test Review Schedule

DMAS is flexible and will work with each contractor to establish a test schedule. Test files should be planned and never sent without approval and knowledge by DMAS. Please contact the DMAS Encounter Analyst, Jill Gambosh, at 804-786-7346 to set up your test schedule. Test data received is normally processed by FHSC within two business days.

3. Connecting to FHSC

When you connect to the FHSC server using a secure SSL FTP connection, you should see several folders. Test data should be dropped into the TEST folder. After dropping the test file, you must notify DMAS and FHSC EDI department that you have done so. This can be done by email (edivmap@fhsc.com and Jill.Gambosh@dmas.virginia.gov), . Your notification must include the MCO's service center ID, what type of file you are testing, and who should be notified of the test results.

4. Test Error Notification

Error notification in test mode is manual. Once FHSC has processed the test file, results are communicated Jill Gambosh, who will notify the MCO of the test results. If the test file passed, the MCO will be approved for submission of one production file (see Production Approval below).

If the test file failed, **different** test data are required. Files in the "TEST" folder are deleted only when the test system is refreshed, which is approximately twice a year. Correcting the same data and resending will result in the denial of all resubmitted records as duplicates.

5. Production Approval

If the test file is passed, one production file is approved and submission results are reviewed. If the production file does not pass appropriate edits, the MCO will need to return to the test process until a production file is approved.

E. Live Transmissions

1. Data Submission

After the MCO receives authorization for production transmission, it may submit files on a monthly, semi-monthly or weekly schedule. DMAS will work with the MCO to determine an appropriate submission schedule. FHSC plans its work around the monthly submission calendar; once the schedule is established, you will need to notify Jill

Gambosh ahead of schedule if you will miss a date. You can also schedule a new date for submission at that time.

(This was already stated)

Shortly after the MCO submits the file to the FTP "INCOMING" folder, it can check the FTP "OUTGOING" folder for a file named xxxxxxxx.rpt (xxxxxxxx is the Media Control Number or MCN assigned by FHSC). Each file received by FHSC is assigned a unique MCN. When this file is opened, it displays a report similar to that on the confirmation screen of the bulletin board. It will show the file's original name and the new name assigned by FHSC.

Once the MCN number(s) has been assigned by FHSC, the MCO/vendor should email encounter notifications to the following:

EDIVMAP@FHSC.com – This one address will be delivered to several staff members at FHSC and
Jill.Gambosh@DMAS.virginia.gov – Contract Monitor/Reporting Analyst for Encounters

The fee-for-service non-emergency transportation vendor should also email:

Bill.Zieser@DMAS.virginia.gov

The State's contracted dental vendor should also email:

Sandra.Brown@DMAS.virginia.gov and
Lisa.Bilik@DMAS.virginia.gov

The following information should be included in the email for each encounter file delivered to FHSC:

Submitter: MCO Plan Name/Vendor Name
File Name: Subcontractor name or source; e.g., Vision, Mental Health, etc.
File Type: HCFA, UB, Dental, NCPDP
MCN: MCN assigned by FHSC
For: Month and year reflecting the period submitted; e.g., January 05
No. of Records: The number of records included in the file

2. Feedback from FHSC

The FHSC Gateway checks for new production files at the top of each hour. At the half hour, a 997 (Functional Acknowledgment) for 837s or an RSP for NCPDP files will post for MCO/vendor review. MCOs should check the 997/RSP to see whether or not the file was accepted. The naming convention for the files is:

<Four-digit service ID>_997_<MCN>

<Four-digit service ID>_RSP_<MCN>

If the ISA or ISE segments are invalid and a 997 record cannot be generated, FHSC will contact the MCO directly. If there is a negative 997 (that is, the ST and/or SE segments fail), a trace report will be downloaded to the FTP site. Contact FHSC for assistance reading this report at 1-800-924-6741. The naming convention for this report is <Four-digit service ID>_ERROR_<MCN>.

Encounters received from an MCO on Monday through Thursday of a given week (no encounter submissions are accepted on Friday) that are not rejected are processed that weekend. Several reports are generated that are posted by FHSC. These reports are zipped and posted in the "OUTGOING" folder on Monday morning. The naming convention for this file is <Four-digit service center ID>_<MCN>. Once the file is unzipped, four reports are displayed:

- CP-O-507: Encounter Summary Report – summarizes the entire submission
- CP-O-506-01: Encounter Error Report – lists every claim that was submitted with an error status of 2 or higher
- CP-O-506-02: Encounter Detail Report – includes **all** claims submitted, including those passed with an error code of zero
- CP-F-510: EFL – electronic version of the Encounter Error Report

3. MCO Responsibilities for Correction and/or Resubmission

If an entire file is rejected (i.e., has only a 997 transaction in the OUTGOING folder), the MCO should correct any formatting or syntax errors in the file and resubmit.

Encounters that were denied by the MCO (error code = 9) require no further action by the MCO, unless the encounter is subsequently corrected and "paid" by the MCO. In that case, the corrected encounter should be submitted as an adjustment.

Encounters with a fatal error (status = 8) must be corrected, if possible, and resubmitted as a void and replacement. Corrections must be made within 30 days of error notification date, which is considered the Monday following weekend processing.

Encounters with a status of "6" (critical error) should be reviewed by the MCO. There is no need to correct and resubmit transactions with this error code. It is anticipated, however, that these errors will become fatal errors in the future. By reviewing these errors now, the MCO may be able to identify errors that they are introducing or, in some cases, that DMAS is incorrectly setting. If the MCO and/or DMAS can correct these errors now, future data submissions will result in fewer fatal errors.

Transactions assigned an error code of "2" (non-severe error) or "4" (moderate error) require no action on the part of the MCO. However, if a high volume of these errors occurs because the VaMMIS edits are set incorrectly, the MCO should report this situation to DMAS for investigation and possible correction.

MCOs should reference their contract with DMAS to understand other obligations under the contract.

V. ENCOUNTER DATA CERTIFICATION

By the 15th of each month, MCOs must certify the data submitted in the prior month. Please reference your contract or RFP for data certification requirements. MCO data certifications are submitted to the MCO Compliance Analyst (currently Vivian Horn). Transportation and Dental certifications are submitted to the Encounter Analyst (currently Jill Gambosh).

The Encounter Data Certification Form will change beginning July 2006 to protect the privacy and confidentiality of payment information that will be collected from the MCOs at that time. Additional language has been added to the form in order to protect the privacy and confidentiality of the MCOs payment information. It is important that you use this version of the form for certification in order to insure your payment information is not released under Freedom of Information Act requests.